PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Testosterone topical

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

Drug product:
- ☐ Testosterone 10mg (2%) gel
- ☐ Testosterone 12.5 mg (1%) gel
- ☐ Testosterone 25 mg/2.5 gm (1%) gel
- ☐ Testosterone 50 mg/5 gm (1%) gel
- ☐ Testosterone 30 mg topical solution

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have a diagnosis of hypogonadism or another medically-accepted indication*
2. Must be male
3. Must have a serum total testosterone level less than 300 ng/dL on more than one occasion in the past year
4. Must have clinical signs and symptoms consistent with androgen deficiency
5. Must be screened for prostate cancer before starting therapy and routinely while on therapy (if appropriate):
   - Required for men over age 50
   - Required for men over age 40 who are African-American or have a family history of prostate cancer
6. Must have a documented trial and failure to a generic injectable testosterone product**
   - Failure is an intolerance or an inability to improve symptoms or testosterone levels after 2 months of therapy

**Note: This requirement only applies to members who are enrolled in a MAPD (Medicare Advantage Prescription Drug) plan.

Additional information

Note: When criteria are met, duration of approval is 1 year

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 11/2019

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Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- —— *or* —— supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Hypogonadism
☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

B. Has the patient had more than one serum total testosterone level < 300 ng/dL in the past year?

☐ Yes

Lab Date	**Result**	**Interpretation**		
_____	_____ ng/dL	☐ high	☐ low	☐ within normal limits
_____	_____ ng/dL	☐ high	☐ low	☐ within normal limits

☐ No**. Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

C. Does the patient have clinical signs and symptoms of hypogonadism?

☐ Yes
- ☐ Decrease in energy
- ☐ Decrease in muscle mass
- ☐ Fatigue
- ☐ Difficulty concentrating
- ☐ Gynecomastia
- ☐ Hot flashes
- ☐ Other: _____

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

D. If appropriate based on risk factors and age, has the patient been screened for prostate cancer?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

E. Has the patient tried and failed a generic injectable testosterone product?**

☐ Yes. Check all that apply:
- ☐ Testosterone cypionate
- ☐ Testosterone enanthate

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

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F. What was the reason for failure to the generic injectable testosterone product?**

☐ Intolerance – *Reaction:* _____

☐ Inability to improve symptoms or testosterone levels after 2 months of therapy

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would testosterone topical gel or solution likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using testosterone topical gel or solution, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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